STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G559	A. BUILDING 00 B. WING	05/23/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARC OF NORTHWEST INDIANA INC, THE	2901 BEVERLY DR GARY, IN 46408

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W0000	This visit was for investigation of complaint #IN00108288. Complaint #IN00108288: Substantiated, federal/state deficiency related to the allegation is cited at W331. Dates of Survey: May 21, 22 and 23, 2012. Facility Number: 001073 Provider Number: 15G559 AIMS Number: 100239890 Surveyor: Claudia Ramirez, RN, Public Nurse Surveyor III/QMRP This deficiency also reflect state findings in accordance with 460 IAC 9. Quality Review completed on 6/4/12 by Tim Shebel, Medical Surveyor III.	W0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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W0331	483.460(c) NURSING SERVICES The facility must provide clients with nursing services in accordance with their needs. Based on record review and interview, the facility failed for 1 of 2 sampled clients (client A) by not ensuring client received nursing services according to their medical needs with concise documentation of condition, by not ensuring staff correctly documented new medication client MAR (Medication Administration Record) and by not ensuring client medications did not contain medications to which the client was reported to be allergic. Findings include: On 05/21/12 at 1:45 PM a record review of the BDDS (Bureau of Developmental Disabilities Services) reports was completed and included the following incident: 05/13/11: A BDDS report submitted 05/09/12 for an incident on 05/09/12 at 4:30 AM indicated the following regarding client A: "[Client A] was taken to the hospital on 05/07/12 from the group home with the symptoms of loose stools, sweating, and moaning. She was admitted with a diagnosis of severe UTI	W0331	Community Services Nurse will re-train DSPs on proper documentation of all medication that is given to a client. Community Services Nurse will monitor all medications so that no allergy conflicts occur.To ensure future compliance, Community Services Nurse and/or Service Coordinator will monitor MAR bi-weekly for 3 months and monthly thereafter. 6/22/12 submitted W331 – Community Services Nurses was trained on June 1 st , 2012 on the mandatory necessity to physically assess a client if it has been reported that the client is having non life threatening symptoms, change of condition or complaints that are continuing for more than 24 hours . If it's impossible for the Nurse to assess the client in a timely manner, the client must be taken to the Doctor or Hospital for further medical evaluation. To ensure future compliance, the Director of Health Services has implemented a log book that the Nurse will take home with them every evening, and record all calls regarding these types of situations. The book will be reviewed by the Director of Health Services (RN) daily	06/22/2012

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	(Urinary Tract Infection). [Client A] passed away at the hospital at approximately 4:30 AM. A death investigation has been initiated by the agency." Client A's records were reviewed on 05/21/12 at 2:00 PM. Client A's record review included review of the following dated documents: 04/16/12: Daily log indicated client A did not want to sit and she had a boil on her leg. 04/17/12: Cumulative Medical Record indicated client A had an appointment scheduled for the wound clinic but the MD (medical doctor) canceled the appointment and it was rescheduled for 04/19/12. 04/19/12: Wound clinic visit indicated the wound was cleaned and cultured and client A was placed on antibiotic oral medication along with "Santyl" ointment and the dressing was to be changed daily and the Santyl ointment was to be used daily. 04/2012: MAR did not indicated the Santyl ointment had been started or administered in April 2012.		to monitor for appropriate response. All phone calls that the Nurse receives will be discussed at our daily morning meeting, to assure that appropriate and prompt response was rendered.	

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	04/24/12: Wound clinic visit indicated a, "non-healing L (left) posterior thigh wound." The MD ordered Cleocin. 05/01/12: Wound clinic visit indicated the wound still was not healing, the Santyl ointment was discontinued and a new dressing was placed and the instructions indicated the new dressing should stay intact for a week. 05/03/12: Daily log indicated client A returned home from dayservice early due to being "sick" and with a temperature of 101.1. The MAR indicated Tylenol was administered but the MAR contained no documentation of what time it was given or the results. Staff #1's investigative statement dated 05/09/12 indicated she gave client A the medication Imodium for diarrhea. The MAR did not contain any information indicating client A had received Imodium on 05/03/12. 05/04/12: Daily log indicated client A had loose stools twice, a temperature of 100.4 and went to workshop. The record did not indicated what time the temperature was taken. The MAR for 05/04/12 indicated client A received one dose of Tylenol and two doses of Imodium, however the MAR contained no documentation what time the medications were given nor the results of			

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	the medications. The daily log indicated client A had improved by 10:00 PM. 05/05/12: Daily log indicated client A had "loose stools over night" but did not record the number of the stools. The log indicated client A had a, "sore bottom, wetting on self, possible infections, do not want to be touch[ed] her vagina, nurse called." The MAR indicated client A had received one dose of Tylenol and three doses of Imodium, however the MAR contained no documentation what time the medications were given, nor the results of the medications. 05/06/12: Daily log indicated client A was sick and had diarrhea, but did not indicate the number of diarrhea episodes she had. The MAR indicated client A had received two doses of Tylenol and three doses of Imodium, however the MAR contained no documentation what time the medications were given, nor the results of the medications. The log indicated the nurse was contacted and the diarrhea slowed down after lunch and no diarrhea overnight. 05/07/12: Staff #2's investigation interview indicted client A had a soft/thin BM (bowel movement) before the bus arrived. Client A went to work shop and the staff log indicated she vomited the			

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	Cleocin with or without food. Client A had an appointment to see the MD 05/08/12. The group home nurse contacted the MD before noon and advised MD nurse all of client A's symptoms including wetting on self on 05/05/12, vomiting, diarrhea, temperatures and decreased eating. Group home nurse was advised to discontinue the Cleocin (which is know to cause diarrhea) and the MD would see client A the next day on 05/08/12 as scheduled. The MAR indicated the Cleocin was discontinued. The MAR indicated client A received one dose of Tylenol and one dose of Imodium. The MAR contained no documentation of what time the medications were given nor the results of the medications. The group home nurse's investigation statement dated 05/09/12 indicated she spoke with the staff at approximately 8:30 PM and the staff indicated client A had eaten some dinner and seemed to be doing better. Client A had a temperature of 99.1 and one loose stool. The statement indicated at 11:30 PM she received a call on the nurse emergency phone that client A had been sweating, moaning and "didn't look good" and the staff had called 911 and the ambulance was on the way to the group home. 05/2012: MAR contained no monitoring			

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	of client A's intake and output. The MAR indicated client A was allergic to Phenothiazines (drugs that treat serious mental and emotional disorders, to control agitation and severe nausea and vomiting and severe pain). Client A's MAR contained an order for Promethazine 25 mg (milligram) suppository; insert 1 suppository rectally as needed for vomiting. The MAR indicated the medication was not a routine medication, however the medication contains phenothiazine which client A is allergic to. The MAR did not indicate client A had received any of the suppositories in May. On 05/22/12 at 12:45 PM, an interview was conducted with the QMRP (Qualified Mental Retardation Professional). The QMRP indicated client A went from the group home to the ER (Emergency Room) on 05/07/12 with a diagnosis of UTI and was held in the ER until a bed was available in ICU. She indicated client A was responsive at the group home and in the ER. Client A was moved to the ICU (Intensive Care Unit) was breathing on her own and her family was with her. The QMRP indicated on 05/09/12 client A's condition further deteriorated and CPR was being performed and the family after 10 minutes without a response from client A requested CPR be ceased and client A			

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	died at 4:30 AM on 05/09/12. On 05/22/12 at 12:45 PM, an interview was conducted with the Licensed Practical Nurse (LPN). The LPN indicated client A had been treated at the wound clinic for a boil and the wound was not healing. She had been placed on a second round of Cleocin and when she contacted the MD and advised of all of client A's symptoms it was felt they were related to the Cleocin. The medication was stopped on 05/07/12 and the MD planned to see client A the following day 05/08/12. The LPN indicated during the course of treatment she had advised staff to push fluids, however there was no documentation of client A's Intake and Output and there should have been. She also indicated staff should have recorded the dated and time of the Tylenol and Imodium doses and the results of the medications and they failed to do that. She further indicated the medication client A was allergic to should not be on the MAR and the ointment which was ordered on 04/19/12 had been received and she was aware staff were using it, however there was no documentation on the MAR to indicate the order was being carried out and that client A was receiving the care and monitoring she needed to have for her symptoms.			

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